



PAUL, 2020

LEARNING FROM SARs

www.northlincssab.co.uk

BACKGROUND:

Paul died due to alcohol and drug use in 2019. He was 44 years old. Paul slept on the streets and experienced drug and alcohol addiction. Paul was trusting and friendly which made him vulnerable to being exploited. Paul experienced abuse and exploitation, both when in accommodation and sleeping rough.

KEY ISSUES:

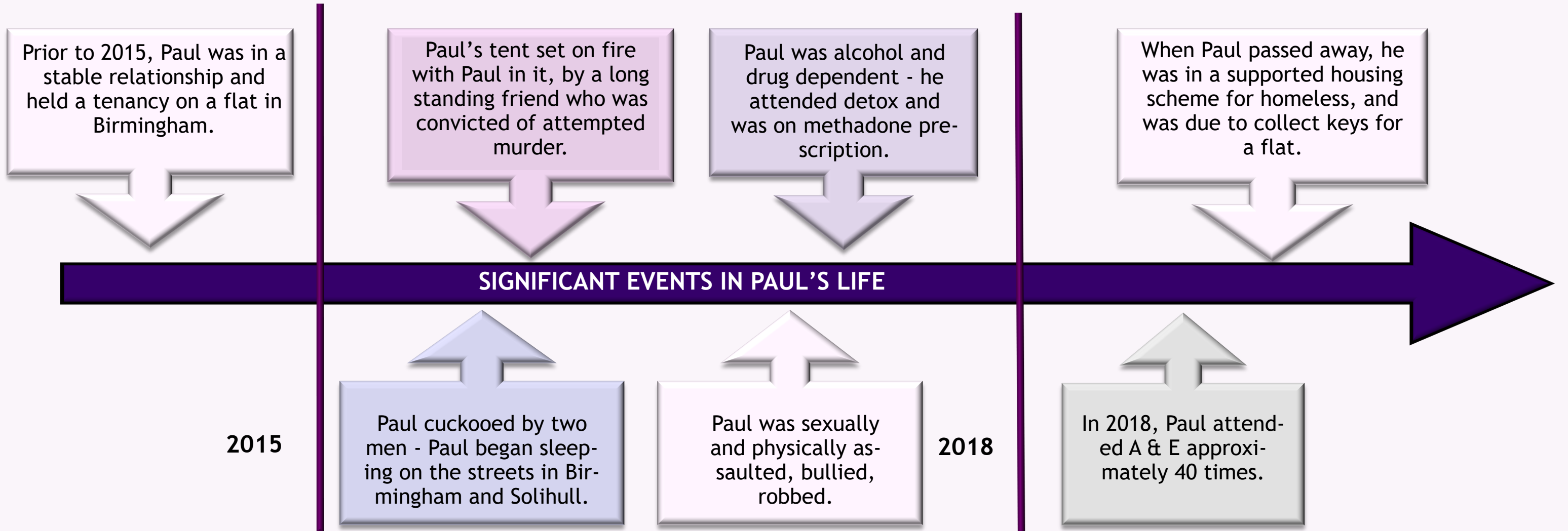
Transitions: Paul moved between Birmingham and Solihull - not known to Solihull ASC, new relationships, discharges from hospital not collaborative, self - discharges without treatment.

Holistic approach: missed opportunities to recognise patterns, and no evidence of structured partnership working.

Legal literacy: inconsistent responses from safeguarding - varying interpretations of Paul's vulnerabilities, eligibility, and 'lifestyle choices.'

Training, skills, and knowledge: lack of knowledge in relation to working with people with multiple disadvantages, varying models of engagement with rough sleepers, lack of professional curiosity in relation to potential self - neglect, no evidence of formal mental capacity assessments, or if Paul was the victim of coercion.

Conditional support: provision of accommodation under condition of abstaining from alcohol and drug use.



POSITIVE FINDINGS:

In the last few months of Paul's life, he was accepting and receiving support from a number of agencies to address homelessness and substance misuse.

The agencies were coordinated and felt clear about one another's role and remit.

ARE WE PREPARED IN NORTH LINCOLNSHIRE?

- Are you aware of services, pathways and multi - agency decision making panels available to professionals working with homeless people in our area? Do you know where to access information and advice?
- How confident are you in understanding and supporting adults experiencing multiple disadvantages i.e., when to submit a safeguarding concern, how to assess mental capacity, how to identify coercion? Do you have access to ongoing training in those areas?
- Does your organisation regularly audit cases where decisions are made not to progress a safeguarding to LA? Is the decision making evidence based? Is it appropriate? Is it consistent?
- How might a safeguarding response have helped in this case?



ADDITIONAL INFORMATION

LEARNING AND WHAT HAPPENED NEXT?

- Solihull housing service implemented homelessness strategy and initiatives to support rough sleepers.
- Homelessness Reduction Act 2017 - Biggest change to homelessness legislation in 40 years and brings in new duties to prevent and relieve homelessness.
- Housing First - Gives people who have experienced homelessness and chronic health and social care needs a stable home from which to rebuild their lives.
- St Basil's - Drop in project for those at risk of homelessness, floating support for young people at risk of homelessness, emergency accommodation, and supported accommodation scheme for young people.
- Solihull Integrated Addictions Services (SIAS) - Partnership between five organisations jointly responsible for the delivery of drug, alcohol and gambling services in the area.
- Change Into Action - Alternative giving scheme where the public are encouraged to donate to local organisations rather than directly to those people who are begging. The money is used to help to change the circumstances of rough sleepers and those at risk of rough sleeping.
- Solihull's Harm Reduction and Vulnerable Victims Forum - Set up on behalf of the Safer Solihull Community Safety Partnership and Solihull SAB to effectively case manage and provide a multi - agency response to vulnerable individuals who may be victims of hate crime, antisocial behaviour, and repeat callers to emergency services and partner agencies.
- Street Link - National website, mobile phone app, and telephone service for anyone to raise an alert that a person is sleeping rough, so positive action can be taken.

LEARNING AND WHAT HAPPENED NEXT? CONT'D

- Rough Sleeper Coordinator - Responsibility for Solihull's policy to prevent rough sleeping, implementing current strategy and policy and identifying and addressing gaps in existing provision. Coordinating partners across the statutory and voluntary sector to share information and agree appropriate service responses to known and suspected rough sleepers.
- University Hospitals Birmingham Homeless Pathway - Involves organising healthcare services in the hospital setting to promote safe discharge, coordinating external agencies such as housing, social care, the voluntary sector alongside specialist community services to build a care package.
- The Care Act 2014 - There are a number of sections which would be relevant in supporting an adult who is experiencing or at risk of homelessness. Section 1 (LA's duty to promote wellbeing), Section 9 (LA's duty to carry out needs assessment), Section 11 (circumstances when LAs should carry out needs assessment when someone refuses), Section 42 (LA Safeguarding Adults duties), Section 67 and 69 (details when LA must arrange independent advocacy support).
- Care and Support Statutory Guidance - Interpretation of Statutory Guidance on application of Section 42 safeguarding duty varies nationally. Para. 14.44 allows for LAs to choose to undertake safeguarding enquiries for adults where there is not a S42 duty, if it is proportionate to do so. Again, use of this power across the country is variable and there is a need to explore this further.
- A positive finding - In the last few months of Paul's life he was accepting and receiving support from a number of agencies to address homelessness and substance misuse. The agencies were coordinated and felt clear about one another's role and remit.

RECOMMENDATIONS

- SAB to seek assurance services, pathways, and multi - agency decision making forums are available to professionals who work with adults experiencing or at risk of homelessness, are clear and this collective resource is widely available and kept up to date.
- To explore levels of confidence and understanding in supporting individuals experiencing multiple disadvantages, including when to refer as a safeguarding concern, how to assess mental capacity and how to identify coercion, and to consider a training programme to address gaps.
- Partners are asked to consider auditing cases where decisions are made not to progress a safeguarding concern to the LA, to ensure that decision making is evidence based, appropriate and consistent.

FURTHER RESOURCES

- Safeguarding Adults Review Report - Paul [Overview-Report-Paul.pdf \(safeguardingsolihull.org.uk\)](http://safeguardingsolihull.org.uk)
- Safeguarding Adults Review Practice Briefing - Paul [Paul-Practice-Briefing.pdf \(safeguardingsolihull.org.uk\)](http://safeguardingsolihull.org.uk)
- [North-Lincolnshire-MA-PP-FINAL.pdf \(northlincssab.co.uk\)](http://northlincssab.co.uk)
- [North-Lincolnshire-VARM-Policy-FINAL.pdf \(northlincssab.co.uk\)](http://northlincssab.co.uk)